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Published in:
Health Policy

DOI:
[10.1016/j.healthpol.2015.02.012](https://doi.org/10.1016/j.healthpol.2015.02.012)

Publication date:
2015

Document Version
Publisher's PDF, also known as Version of record

[Link to publication in ResearchOnline](#)

Citation for published version (Harvard):

Holmes, RD, Steele, JG, Donaldson, C & Exley, CE 2015, 'Learning from contract change in primary care dentistry: a qualitative study of stakeholders in the north of England', *Health Policy*, vol. 119, no. 9, pp. 1218-1225. <https://doi.org/10.1016/j.healthpol.2015.02.012>

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Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol



Learning from contract change in primary care dentistry: A qualitative study of stakeholders in the north of England

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ARTICLE INFO

Article history:

Received 12 December 2014

Received in revised form 16 February 2015

Accepted 17 February 2015

Keywords:

Dental care

Dental practice

Qualitative research

Health resources

ABSTRACT

The aim of this research was to explore and synthesise learning from stakeholders (NHS dentists, commissioners and patients) approximately five years on from the introduction of a new NHS dental contract in England. The case study involved a purposive sample of stakeholders associated with a former NHS Primary Care Trust (PCT) in the north of England. Semi-structured interviews were conducted with 8 commissioners of NHS dental services and 5 NHS general dental practitioners. Three focus group meetings were held with 14 NHS dental patients. All focus groups and interviews were audio recorded and transcribed verbatim. The data were analysed using a framework approach. Four themes were identified: 'commissioners' views of managing local NHS dental services'; 'the risks of commissioning for patient access'; 'costs, contract currency and commissioning constraints'; and 'local decision-making and future priorities'. Commissioners reported that much of their time was spent managing existing contracts rather than commissioning services. Patients were unclear about the NHS dental charge bands and dentists strongly criticised the contract's target-driven approach which was centred upon them generating 'units of dental activity'. NHS commissioners remained relatively constrained in their abilities to reallocate dental resources amongst contracts. The national focus upon practitioners achieving their units of dental activity appeared to outweigh interest in the quality of dental care provided.

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1. Introduction

In April 2006, primary care National Health Service (NHS) dental services in England and Wales began operating under a 'new' general dental services (nGDS) contract. Fundamentally, three major changes impacted upon NHS dental services at this time. First, financial resources for

NHS dentistry became overtly 'cash limited' [1] when resources were devolved to Primary Care Trusts (PCTs) in England and Local Health Boards (LHBs) in Wales from the national budget. The devolution of resources and decision-making responsibilities to PCTs and LHBs marked the beginning of local dental commissioning which in turn opened potential opportunities for the local prioritisation of resources [2]. Commissioning is the term used to describe a 'proactive strategic role in planning, designing and implementing the range of services required' [3]. Although this activity was only introduced to NHS primary care dental services in 2006, NHS commissioning in the whole of the UK began in the early 1990s when

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<http://dx.doi.org/10.1016/j.healthpol.2015.02.012>

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the purchaser/provider split was introduced as part of the quasi-internal market. Despite devolution leading to a divergence in the structures of the NHS and social care systems across the four nations of the UK, and a greater resultant focus in each country on more local issues, the term ‘commissioning’ is still used UK-wide. Consequently, the effectiveness of commissioning, the impact of wider NHS reforms and the performance of the NHS across all four UK countries since devolution continue to be the subject of much research, analysis and cross-border learning [4–7].

The second change affecting primary care NHS dental services in England and Wales in 2006 was the introduction of a new contract currency, the ‘unit of dental activity’ (UDA). UDAs are the unit of currency for measuring the type of clinical activity performed by dentists within a 12-month contract for an agreed financial value [8]. The financial value of a UDA varies between dental practitioners as a consequence of a decision to use a 12-month ‘test’ period during 2004–2005 as the basis for calculating dentists’ annual salaries. Differences in the volume and type of dental treatment activity conducted during this reference period have resulted in the financial value of one UDA typically ranging between £17 and £40 [8]. The UDA has attracted much criticism from dental practitioners who cite inequity regarding variable UDA rates and a target-focused mentality which has often resulted in anxiety resulting from the financial implications associated with contract underperformance [9,10].

The third significant change impacting upon NHS primary care dental services in England and Wales was the introduction of a new patient charge system which reduced over four hundred different NHS dental charges to just three broad charge bands. The ‘NHS Dentistry: Patient Charges Working Group’ who developed these charge bands involved both patient groups and representatives of the dental profession [11]. There was a desire to simplify patient charging and uncouple the direct link between dentists’ remuneration and individual items of treatment activity. However, neither the patient charge bands nor the UDA system were piloted prior to their implementation in April 2006.

In 2008 the House of Commons Health Committee published a highly detailed report on NHS dental services. The Committee found that in-house commissioning skills varied greatly between PCTs and that too many PCTs were ‘not doing a good job’ [12]. The Government responded by acknowledging the variable quality of dental commissioning between PCTs, alongside other aspects linked to the nGDS contract [13].

In response to this report, an independent review of NHS dental services was commenced, and then published in June 2009. The report called for dental contracts to be developed with clearer incentives for improving health, access and the quality of dental treatment [14]. A ‘staged pathway through care’ was suggested by the authors of the review as a means of encouraging continuity of care between patients and dentists. Additionally, the review team reported ‘...there is some very good commissioning taking place but it is by no means universal’ [15]. Evidence gathered since 2006 has indicated that measures used in

the nGDS contract have concentrated upon quantity not quality [16]. From a resource allocation perspective, several studies have also noted that the focus for some NHS organisations has been upon day-to-day management of existing contracts rather than the true commissioning of dental services [17,18].

Since this study was undertaken, the former 152 PCTs across England have been abolished and NHS dentistry is now commissioned by one organisation—NHS England (NHSE) with a regional structure. These developments will be considered later in light of the results from this study. However, whilst the organisational structure of dental commissioning has now changed across England, the same principles of commissioning apply.

Following introduction of the 2006 nGDS contract, the parliamentary inquiry [19], the independent review of NHS dental services [14] and three years of piloting, there is now the prospect of a ‘reformed’ dental contract. The aim of this paper is to synthesise the learning from stakeholders directly involved, and explore the impact of the 2006 nGDS contract to inform the new plans for reform.

2. Method

2.1. Setting

The study was conducted in a large NHS commissioning organisation (combining 2 neighbouring PCTs) in the north of England.

2.2. Design and sample

To explore the impact of the 2006 nGDS contract upon key stakeholders, a qualitative case-study design was chosen as there have been calls for case-studies to provide the much needed exemplars to support social science [20]. Case study approaches can also facilitate the study of more complex and integrated systems such as health care organisations [21].

The study involved three stakeholder groups: patients; primary care dental practitioners and NHS commissioners. Semi-structured interviews and focus groups elicited the opinions of participants about the nGDS contract and local NHS dental services. Semi-structured interviews were conducted with 8 of the 9 PCT staff members who held responsibility for commissioning local NHS dental services. One senior PCT staff member declined to participate citing pressure of work.

Two local public engagement groups were contacted to represent NHS patients and service-users. Local NHS dental practitioners were identified with the assistance of the PCT’s dental practice advisor (DPA). A purposive sampling strategy was used to identify: dentists with varying levels of NHS experience; a combination of principal dentists (providers), associate dentists (performers) and a dental practice owned by a large corporate body. PCT staff members were contacted by one member of the research team (RH). Potential participants received a letter about the study together with a detailed information sheet and consent form.

In total, 27 participants were recruited to the study: 14 local NHS dental patients, 8 local dental commissioners and 5 local NHS general dental practitioners.

2.3. Data collection

One member of the research team (RH) conducted all of the semi-structured interviews and focus groups. The interviews with NHS general dental practitioners took place in their dental practices. For NHS commissioners, interviews took place at the PCT headquarters. The focus groups with patients were held in neutral venues. A pre-piloted topic guide was used to prompt the interviewer and this was modified during the data collection process. Focus groups and semi-structured interviews were audio-recorded and professionally transcribed verbatim.

2.4. Data analysis

Each transcript was reviewed against the original audio-recording to ensure that the conversion of speech to text had been prepared accurately [22]. Three members of the research team then independently familiarised themselves with the transcripts in order to build a provisional overview of the emerging issues as proposed by Framework analysis [23]. The data contained in the transcripts were then coded line by line before being entered into a spreadsheet matrix to assist in the identification of themes. Data were analysed manually. Finally, the research team met on several occasions to agree the thematic framework.

2.5. Research ethics

The study received a favourable ethical opinion (Research Ethics Committee Reference: 10/H0908/9) and research governance approval was granted by the NHS commissioning organisation involved. To protect participants' anonymity, these organisations and the gender of the stakeholders involved have been removed from quotations within the Results section.

3. Results

Four themes emerged from the data: (1) commissioners' views of managing local NHS dental services; (2) the risks of commissioning for patient access; (3) costs, contract currency and commissioning constraints, and (4) local decision-making and future priorities. Verbatim quotations are used as examples to provide context to the issues raised by participants.

3.1. Theme 1: Commissioners' views of managing local NHS dental services

Dental contract management was driven by local commissioners who monitored practitioners' ability to achieve UDAs in compliance with national nGDS regulations and their annual contract values. This target-based approach appeared to dominate at the expense of other potential performance indicators.

Commissioners are focused very much on the number of patients seen by a dentist, regardless of quality. . .you're commissioning on units of dental activity and on the number of patients, not on quality or outcomes or prevention. (ID6, commissioner)

Five years on from the introduction of local dental commissioning, dental contract management (rather than the true commissioning of dental services) continued to dominate the workload of staff.

There needs to be a fundamental shift from administering contracts to commissioning them. . .there needs to be more robust commissioning of dental services. (ID7, commissioner)

Nationally, there continues to be a concerted effort by the Department of Health to continually increase patient access to NHS dentistry. Consequently, for commissioners, their focus appeared to revolve around achieving quantitative access targets.

A lot of the problem has been. . .the focus on [patient] access and people have taken away from that various messages. . .some of those messages have been 'hit the numbers irrespective of the quality', in other words it doesn't matter who you get in [to dental services], even if they have no health care needs at all—that's a figure you can count. (ID7, commissioner)

However, in the north of England where this study was based, patient access to dentistry was arguably not as severe as the problems experienced in the south of the country. This led to a sense of frustration for some commissioners, who found the unrelenting national focus upon improving patient access at odds with the needs and demands of the local population. In other words the central demands were not aligned with local needs.

3.2. Theme 2: The risks of commissioning for patient access

Access to NHS dental treatment was a significant concern for the patients recruited to this study. However, participants' concerns focused around having to travel relatively long distances to access NHS dental practices as a consequence of the large geographic area.

To get people from [location] to go to the dentist is a nightmare because they tend to only go when the tooth is absolutely killing them; they don't do regular appointments. . .you've got to get two buses at least. . .you don't bother. . .you've got to go further afield and people are terribly parochial. (P4, NHS patient)

However, in contrast to the quotation above, a new NHS dental practice had been commissioned locally but the service ultimately failed, due largely to a low level of patient utilisation. At a separate interview, a local NHS dental practitioner wished to discuss this specific example.

I know the PCT have thrown a lot of money at the rural surgeries. I think they had to close one in [location] because they just didn't have enough patients there. . .whereas they

would have been a lot better off having given that money to the city centre. People from outside the city can easily get a bus here and they're coming anyhow to do their shopping. It's not necessary to put all that money out in the sticks for a service which isn't going to be used. (ID2, Principal dentist)

This example perhaps highlights issues associated with patients' propensity to seek dental treatment. However, it is acknowledged that the use of resources by commissioners in this case was undoubtedly well intentioned and the issues at play may well have been more complex than those suggested above.

3.3. Theme 3. Costs, contract currency and commissioning constraints

This theme consists of three sub-themes: (3.1) patient charges; (3.2) contract currency (units of dental activity) and (3.3) factors impacting upon business.

3.3.1. Patient charges

The patient charges associated with the three treatment bands encompassed by the 2006 nGDS contract were a major source of confusion for patients in this study. None of the patients recruited were able to describe the NHS dental charge band structure. Of concern, were the number of comments received about 'additional fees' added to financial estimates that were not recognised by the authors as NHS charges relating to Band 1, 2 or 3 treatments.

There always seems to be something sort of added on [to the bill], like an x-ray, a scale. . . extras. (P2, NHS patient)

. . . then there's the hygienist but they're expensive, you're in maybe 15 min and they charge you 30 something pounds". (M3, NHS patient)

The confusion about NHS patient charges may not have been helped by some practitioners' choice of terminology with patients.

. . . the company is keen to offer patients upgrades. We don't. . . necessarily call it private treatment. We call it 'offering them upgrades'. (ID2, Principal dentist, body corporate)

3.3.2. Contract currency (units of dental activity)

Commissioners acknowledged that because the financial value of UDAs varied significantly across local practitioners' contracts, this was often a significant cause of anger for many dentists. Consequently, UDA values fuelled a perception of inequity amongst practitioners.

A UDA value isn't the same or anywhere near perhaps what another dentist would be paid as a UDA value. So, some might be on £18, some might be on near enough £40 a UDA in our PCT. (ID9, commissioner)

One practitioner on a low financial UDA rate explained how this had impacted upon their clinical practise, as patients with high treatment needs and requiring more complex restorative dental care must all be paid for within a single Band 3 patient charge.

I'm seeing a lot of new patients. . . they need crowns, bridges, dentures. . . I can't do anymore this month because my laboratory fees are shooting through the roof. . . my last lab bill was £1,700 for the month. . . I can't afford to do that because that's coming out of my wages. (ID1, dentist)

The UDA-based system reportedly caused varying degrees of stress and anxiety for many NHS general dental practitioners. This quote is from a body corporate employee where the wider company applied pressure to practitioners around achieving their contractual UDA targets.

The biggest concern is the UDAs because obviously the company look at targets and hitting target. If we're not hitting target then we're deemed to be failing. It puts pressure on the dentists. (ID2, Principal dentist, body corporate)

3.3.3. Impacts upon managing local dental services

Commissioners generally reported that they felt significantly constrained in their abilities to manage local NHS dental services. It was reported that almost all of the PCT resource available to fund NHS primary care dentistry had already been allocated to individual practitioners' contracts as a consequence of the decision to remunerate NHS dentists on their activity during the defined 'test' period. So, in reality, opportunities for commissioners to reallocate significant financial resource from one contract to another, or to commission new dental services, were relatively limited. Resource reallocation opportunities only arose where there were significant contract breaches (e.g. underperformance), when practitioners relinquished their NHS contracts or when practitioners agreed to permanent rebasing of their contracts. The following quotations from commissioners provide evidence to support these assertions.

Most resource is tied up, 90% plus is already tied up. (ID7, commissioner)

The budget is really tight. The only way we are going to get money is through rebasing contracts where people are underperforming. . . so we're finding out we've got our hands tied really. (ID10, commissioner)

Although commissioners sought financial 'claw-back' from practitioners who significantly underperformed on their contracts, this in itself caused potential problems. The resource released in these scenarios was typically 'non-recurrent' and available for use only in the short-term. This reportedly led to perverse financial situations.

We have too much non-recurrent money—we can't spend it in a sensible manner because if you say to a practice 'have some money for a year' what can they do? They can't employ staff. . . they can't give a dentist a robust contract. (ID6, commissioner)

The process by which the commissioning organisation allocated 'unspent' UDAs as a consequence of dentists' contractual underperformance, was unclear to the research team as well as local dental practitioners. Unspent UDAs are important marginal resource and they offer flexibility around commissioning. Commissioners reported that 'internal deliberation' drove decision-making about

unspent UDAs. However, general dental practitioners believed there was room for greater transparency.

You always wonder about the transparency of UDA allocation. How does it work? . . . How's the commissioning all gone about? . . . (ID2, Principal dentist, body corporate)

3.4. Theme 4. Local decision-making and future priorities

This theme concentrated upon engagement between NHS dentists and commissioners (4.1), the decision-making processes involving commissioners with respect to resource allocation (4.2) and suggested future priorities for local dental services moving forward into the future (4.3).

3.4.1. Engagement between dentists and commissioners

Local dentists acknowledged that the balance of power was held by their local commissioning organisation.

It's like what they say, goes. You have no negotiation. Everyone is scared about not reaching their [UDA] targets. . . I find that what the PCT wants to do, they'll do. (ID1, dentist)

In this study, engagement between the commissioning organisation and local dentists was believed to have deteriorated since the introduction of local commissioning. This had not been helped by the rapid turnover of local commissioners.

I would say it's got worse for a variety of reasons. . . there's been a problem with a lot of changes in staff. . . I think there were a lot of promises made. When I came into post a lot of what I got was 'well I was promised this would happen - and it never happened'. (ID9, commissioner)

3.4.2. The decision-making process by commissioners

The level of detail provided by commissioners with respect to decision-making about local resource allocation was disappointing. Only one participant provided a brief overview describing how decisions were made with respect to dental commissioning.

If the PCT has extra money, then cases are usually put forward to use that resource. . . based upon an assessment of need. . . if you look at the investment programme of the PCT over a number of years we've put services into those areas with high needs and a lack of services and they've worked. . . to a variable extent. (ID7, commissioner)

The above quotation links to an earlier theme which explored the risks of commissioning for patient access and the complexities associated with locating new NHS dental services to meet patients' clinical needs. Under-utilisation of new dental services by patients in some areas had clearly resulted in variable commissioning success.

3.4.3. Future local priorities for NHS dental services

Commissioners were acutely aware of the current lack of focus in the nGDS contract upon measuring the quality of care provided by dentists. Almost without exception, quality measures were highlighted as an area requiring greater focus.

I want to look at how we can pay dentists to provide a quality service. . . access for patients is brilliant, but access to a poor quality service, what's the point in that? (ID13, dental practice adviser)

All stakeholders involved in this research agreed on the need for more dental disease prevention activity within the dental contract. The lack of financial reward for dentists undertaking prevention was seen to be a major failing of the current dental contract.

One of the big things that's been lacking really is prevention, because the prevention in the end will help. . . There's no incentive for them [dentists] to do it. Some will do more than others because that's what they're passionate about and some will say 'well, I'm not getting paid for it, so I won't do it. (ID9, commissioner)

We need more money spent on preventative dentistry. . . early treatment is certainly more preventative than later treatment. . . catching children when they're young (F2, NHS patient)

4. Discussion

The three stakeholder groups in our study: patients; dentists and NHS commissioners, universally criticised the current dental system approximately five years after introduction of the nGDS contract and local commissioning. The main issues highlighted by participants will be considered below, in the context of key recent developments in national health policy.

Around the time that our data analysis ended, the Department of Health announced a pilot programme to reform NHS dentistry by introducing a reformed contract to reflect the changing oral health needs of the population [24]. Since undertaking our research, the dental pilot programme has provided substantial evidence suggesting that practitioners and patients strongly support the new preventive care based pathway approach, at least in the early stages [25–27]. However, more work is required on the development of the new dental quality and outcomes framework (DQOF) and its contribution to practitioners' remuneration [28]. Recently, the Department of Health has announced its intention to test prototypes for a possible new system incorporating a blend of activity, capitation and quality payments [29]. Despite the need for more testing, the contract reform programme does appear to be attempting to address many of the areas of criticism raised by stakeholders in this work, but the stakeholders also identified areas that are more difficult to address.

Prior to April 2013, 152 PCTs across England commissioned dental services in different ways. These organisations were sometimes criticised for their variable quality of commissioning [12,30]. With PCTs now abolished, it remains to be seen how effective the new single commissioning organisation (NHSE) will be, as much of the day-to-day business of this large organisation is still managed at local levels through Local Area Teams (LATs) [31]. It is unclear at the moment, how effective LATs will be able to be at managing resource scarcity. However, the units of budgetary allocation should be much larger and

the existence of one commissioning body should encourage whole-England strategic planning and greater consistency [31]. This provides an opportunity for greater flexibility in commissioning.

Research has highlighted that little is known about how effective commissioning is actually achieved in practice [32]. Consequently, it can be useful to draw upon sound principles and learning from wider health care. For example, the effectiveness of future dental commissioning processes could build upon and be measured against the ‘principles of commissioning’ published by the Royal College of General Practitioners (RCGP) [33]. The RCGP commissioning principles are based upon a collaborative; community focused; comprehensive and clinically-led approach to the development of services. Furthermore, The King’s Fund in its document *‘Transforming our health care system’* outlines ten priorities for commissioners [34]. Two of the ten priorities are highly relevant to NHS dentistry as they are directly linked to implementing evidence-based disease prevention interventions on which the dental pilot programme is also focused. Together, both the RCGP and The King’s Fund identify the need to ensure sustainability in the commissioning of health care services in response to ongoing resource constraints and challenging organisational environments. These commissioning principles apply as much to dental services as they do to the wider NHS. Finally, set against the backdrop of devolution and increasing policy divergence across the four countries that comprise the United Kingdom [7], it will be interesting to see how the devolved nations view developments relating to the dental contract reform programme as the prototypes are tested.

The first theme in our paper relates to commissioners’ views of managing local NHS dental services. Key concerns for dental commissioners included that their workload was predominantly focused upon administering existing dental contracts. Similarly, achieving greater patient access to services was perceived to be a higher priority (at the national level) than monitoring the quality of care provided by NHS dental practices even where this did not always align with local priorities. The proposed DQOF, whereby dentists’ work is measured alongside the clinical outcomes they achieve for patients, provides a further opportunity to change the balance, but as the Department of Health accept, there is a need to ensure that the *right* quality and outcome measures are developed and refined [35].

The second theme focused upon the risks associated with commissioning for patient access. In comparison to the former PCTs particularly in the south of England, our study setting did not suffer from significant patient access issues because of a lack of local NHS provision or capacity. Instead, there were significant geographic barriers related to rurality and the long distances that some patients needed to travel to access services. The alignment of national messages and local priorities could remain a tension unless a balance is found. In addition to measuring ‘quality’, the two remaining core elements in the dental pilot programme include ‘capitation’ (paying dentists related to the number of patients under their care rather than the numbers of courses of treatment they provide) and ‘registration’ (encouraging a partnership between patient

and dentist to facilitate health improvement over time) [24]. Both elements have the potential to promote a long-term professional relationship between patient and practitioner.

The third theme relating to costs, contract currency and commissioning constraints identified significant issues for all stakeholder groups involved in the study. Patients reported an overwhelming lack of clarity about the different dental charge bands and the financial costs involved. Dental practitioners criticised local commissioners for a lack of decision-making transparency relating to the award of non-recurrent UDAs and commissioners admitted that their ability to commission local dental services was significantly constrained by national nGDS regulations. The study findings support research which has highlighted practitioners’ frustrations, resentment and reduced job satisfaction since the introduction of the nGDS contract [36,37]. In this study, much negativity centred upon the use of UDAs as a contract currency, strengthening a perception that the contract was little more than a target-based system. Significant variation in the financial value of UDAs generated considerable resentment and a perception of inequity amongst practitioners.

The risks and challenges for dental commissioning in the future are brought into sharp focus by our findings. First, the financial resources associated with primary care nGDS services appear to be largely ‘locked’ within existing contracts based in turn, upon the historic ‘test’ period. For NHS commissioners, this has proved to be a very challenging starting point for the equitable commissioning of local NHS primary care dental services. In April 2006, resources may not have been best placed (geographically) to meet the needs of local populations, and our findings in this case study suggest that commissioners have generally not been able to reallocate NHS dental resources on a large scale because of the nGDS regulations which effectively allow practitioners to hold their NHS contracts in perpetuity (subject to satisfactorily meeting their contractual obligations). This is good for the individual small businesses, allowing stability, but it stifles the abilities of commissioners to address other priorities.

With regard to commissioning challenges, there continues to be significant misalignment between what we know will benefit patients (for example, the application of evidence-based disease prevention interventions [38]), and a lack of financial incentives for practitioners to actually deliver these interventions within the current contract. Additionally, the contract currency (the UDA) has resulted in a perception of inequity amongst practitioners. For those dentists with a relatively low UDA financial value, there is explicit evidence from our study that this has impacted upon their behaviour and clinical practise. Several dentists were explicit that the financial cost to the dentist of providing multiple crowns, bridges or dentures within a single (Band 3) patient charge had made such dental treatment ‘uneconomic’ for practitioners to provide in NHS primary care. In such cases, dentists clearly expected a more directly proportional link between cost and payment for each item of care.

The final theme focused around local decision-making and priority setting. Future priorities for commissioners

and dentists identified a need to focus more upon the quality of dental care which the pilots are now taking forward. All stakeholders recognised the need to make the prevention of dental disease a higher priority. Early findings from the pilot programme have reported that the management of disease risk using a care pathway approach makes clinical sense to practitioners and patients have responded positively with respect to receiving personalised care plans from dentists [25]. However, this can take more time and therefore resource. If this is a priority there may need to be some difficult decisions about what is not such high priority.

There are some limitations associated with our research. Although the study was conducted in a large former NHS commissioning organisation, our results may not have been generalisable to other PCTs that existed across the country. For example, we have already highlighted that the study setting did not reflect the significant patient access issues reported elsewhere and particularly in the south of England. However, our research does support many of the views identified by others since the introduction of the nGDS contract. Indeed, one of the key findings of this study is that over five years on, many of the same contractual issues persist. There are a number of similarities between participants' views in this case-study and an earlier qualitative dental research study conducted across ten former PCTs in England [18]. Research is also exploring the organisation and delivery of primary dental care by comprehensively evaluating a blended contract model compared to the existing nGDS contracts in one area of the United Kingdom [39]. One of the strengths of this study alongside the research findings we have presented is to provide insight into the process of contractual change for the stakeholders involved, prior to the implementation of a reformed national dental contract.

5. Conclusion

This study marks five years on from the introduction of the 2006 nGDS contract in England, yet commissioners continued to report significant constraints in their abilities to reallocate resources between practitioners' contracts, largely as a consequence of historic funding decisions and nGDS regulations. General dental practitioners' contracts resemble budget silos which are not generally amenable to large-scale resource reallocation at local levels in the absence of significant underperformance or more serious contractual breaches.

The national dental contract reform programme has the potential to address some of the concerns expressed by participants in this study. However it is unclear how NHS structural reforms introduced since this study was conducted, will address potential tensions between a national commissioning approach for NHS dental services and the flexibility required by local commissioners. Similarly, at local levels there needs to be a concerted move away from focusing upon the day-to-day administration of existing NHS dental contracts towards the more robust commissioning of NHS dental services by NHS England's Local Area Teams. Despite these concerns, the national dental pilot programme may provide a long overdue opportunity to

improve NHS primary care dental services for the benefit of patients, dental professionals and ultimately, tax payers.

Conflict of interest statement

None declared.

Acknowledgements

The authors wish to thank the patients, general dental practitioners and NHS commissioners who participated in the study. This work is independent research arising from a Doctoral Research Fellowship (DRF-2009-02-63) supported by the National Institute for Health Research. The views expressed in this publication are those of the authors and not necessarily those of the NHS, the National Institute for Health Research or the Department of Health.

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